EXHIBIT D

1550 LIBERTY RIDGE, SUITE 330 WAYNE, PA 19087

WELCOME TO ELAP

Table of Contents

Executive Summary

ELAP Services works with your company to rewrite your Plan and create specific language for reimbursement of hospital or facility claims based on their actual cost to deliver a service, not the inflated billed charges. ELAP then acts as co-fiduciary to your Plan, ensuring that Plan dollars are spent with the same rational business principles that you apply to other aspects of your business. Each eligible claim is sent to ELAP by your TPA, audited, and paid per the Plan limits. In the event of provider pushback on payment, ELAP handles all appeals and balance billing issues from start to finish.

When an employee receives care at a facility such as a hospital, ambulatory surgery center, or skilled nursing center, the bill is sent to ELAP for auditing. During the ELAP audit process, each bill is reviewed line by line and repriced according to the metrics set out in your Plan Document. The amount the Plan will reimburse for services is referred to as the Allowable Claim Limit (ACL). The difference between the billed charges and the ACL is referred to as denied charges. Once the claim has been audited, it is returned to your TPA for payment to the provider.

After each audit, an 'audit package' is sent to both the member and the provider along with payment by your TPA. The member audit package contains two documents; the Participant Notification letter (*sample on page 6*) alerting the member that their claim has been audited, and the Explanation of Benefits (*sample on page 7*) detailing the member's out-of-pocket responsibility. The provider audit package also contains two documents in addition to payment; the Notice of Adverse Benefits letter (*sample on page 8*) explaining why certain charges were denied and detailing the provider's appeal rights and process, as well as a copy of the completed audit sheet. (*sample on page 13*)

Providers have the right to appeal to the Plan in the event that they disagree with reimbursement or other Plan decisions. Typically, the provider will appeal directly to ELAP. All provider appeals are handled directly by ELAP Services, who will review the appeal according to ERISA guidelines. In the event that an additional payment is warranted, the Plan will be notified and the payment will be processed by your TPA.

While the majority of payments are accepted by the provider, members may receive a balance bill for the denied charges. Members receiving a balance bill should forward each bill to ELAP Services as soon as possible at **balancebills@elapservices.com** for defense. A claims examiner and attorney will be assigned to each claim. Members are responsible for paying any out-of-pocket responsibility and should do so as soon as possible. In addition to this, members will need to sign and return an Attorney Client Representation Agreement (*sample on page 16*) and HIPAA Release Form (*sample on page 19*) before the attorney can begin to defend their case. ELAP provides this defense service at **no cost to the member**. Frequently asked questions surrounding balance billing and out-of-pocket expenses can be found on page 23 of this packet.

Finally, ELAP Services provides your company with monthly reporting detailing the Plan expenses and savings as well as a summary of balance bill and appeals information. An example of this report has been included. These reports will give you full transparency, every month, on the performance of the Plan to ensure you are getting optimal savings.

Thank you for choosing ELAP Services! We look forward to working with you. If you have any questions, please contact your Client Relationship Manager.

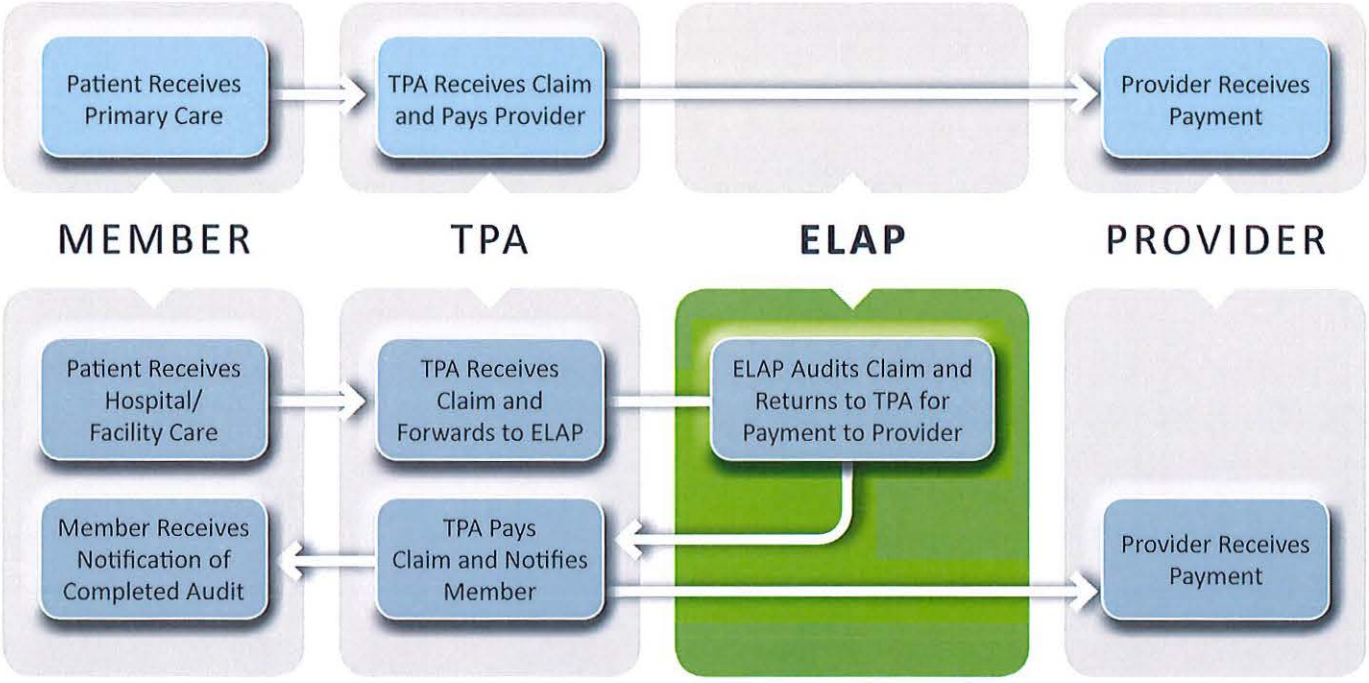
The Claims Cycle

ELAP Services will only be involved in facility claims received from a provider; this could include hospitals, ambulatory surgery centers, skilled nursing care and dialysis centers. All member claims are submitted to your TPA who determines which claims should be sent to ELAP. Claims such as a visit to your primary care doctor, dentist, or eye doctor do not go through the ELAP audit program and are processed by your TPA without any involvement from ELAP.

When a member visits a hospital or other provider they will send the claim to your TPA who will determine its eligibility and then forward the bill on to ELAP. ELAP will audit the claim for billing accuracy and compliance and reprice the claim according to the ACL established in your Plan Document.

The ACL, or maximum reimbursement allowed by your Plan, is determined based on the higher of the Medicare reimbursement rate plus an additional profit margin or, if available, the actual department specific costs reported by the provider to the Center for Medicare and Medicaid Services plus an additional profit margin. By comparing both methods of reimbursement to determine payment, your Plan is ensuring that the provider is being fairly reimbursed for services they performed to both cover costs and provide a reasonable profit.

Audited claims are then sent back to your TPA who pays the provider. The provider also receives information regarding reimbursement, any denied charges, and rights to appeal under the Department of Labor guidelines.



your TPA will send correspondence to both the member and the provider after the completion of an audit. The member receives the **Participant Notification** letter and an **Explanation of Benefits**. The provider receives a **Notice of Adverse Benefits** letter and a copy of the completed **Audit Sheet**.

A sample of the Participant Notification Letter, Explanation of Benefits, Notice of Adverse Benefits Letter, as well as a sample audit are included in this packet for your reference. Below is a brief description of each letter.

PARTICIPANT NOTIFICATION

SENT TO THE MEMBER

The Participant Notification letter is sent out to every member and/or dependent for which ELAP has audited a claim. This letter serves as a notice to members and/or dependents that their claim has been audited and that the medical provider could balance bill them for the difference between what the Plan paid and billed charges, and explains what to do if this happens.

EXPLANATION OF BENEFITS

SENT TO THE MEMBER

The Explanation of Benefits is sent to the member and details the following payment information:

- **What has been paid by the Plan**
- **The excess (not paid) dollar amount noted in the ineligible column**
- **Patient responsibility amounts such as co-pays, deductibles or co-insurance**

NOTICE OF ADVERSE BENEFITS

SENT TO THE PROVIDER

The Notice of Adverse Benefits letter is sent to the provider and explains that the claim has been paid in accordance with Plan limits.

This letter informs the medical provider of their rights to appeal under the Plan, as well as the requirements for filing an appeal with ELAP Services.

AUDIT SHEET

SENT TO THE PROVIDER

The audit sheet details the denied charges of a claim.

Sample Participant Notification

12/08/2014

To: Sample Patient
01 Sample Street
Chester Springs, PA 19425

Re: Sample Group (the "Plan")
Sample Hospital
Date(s) of Service Beginning: 10/27/2014

IMPORTANT NOTICE FROM YOUR PLAN ADMINISTRATOR

DEAR SAMPLE PATIENT:

In accordance with the provisions of the Plan, this letter is to explain the benefit determination for your claim, shown above, and to give you some very important information about the Plan provisions and follow up procedures.

VERY SIMPLY STATED...

- **The Plan audited your claim and paid only the amount of benefits covered by the Plan.**
- **The Plan did not pay the full billed amount.**
- **The medical provider could bill you for the balance of the invoice rather than file an appeal with your Plan.**

If you receive a balance bill, please contact ELAP Services immediately for assistance. Your Plan and ELAP Services will arrange for your legal defense, at no cost to you. Thus, your ongoing involvement will be limited.

PLEASE CONTACT:

ELAP Services, LLC
1550 Liberty Ridge, Suite 330 | Wayne, PA 19087
Customer Service: (610) 321-1008 | Toll Free (leave a message for call back): (800) 977-7381
888- 560-2447
balancebills@elapservices.com

The audit revealed that certain charges exceeded the Plan's Allowable Claim Limits and thus were not paid. Please find the excess (not paid) dollar amount on the Explanation of Benefits (EOB) enclosed, in the "ineligible" column.

Please understand that you may owe some amount to the medical provider for normal out-of-pocket expenses under the Plan, such as deductibles and copayments. These amounts are due and payable by you. Legal defense against collection efforts is for amounts that exceed the Allowable Claim Limits ("ineligible" amount on enclosed EOB).

Your Plan Administrator (Employer) has a fiduciary duty to assess the accuracy and reasonableness of billed charges, to ensure that benefit dollars are spent in the most cost-effective manner for all Plan participants. The audits protect not only your health Plan, they will also protect you, as a healthcare consumer, and will result in savings to both you and the Plan.

Your healthcare provider has received complete, detailed results of the audit and has been afforded full rights of appeal in accordance with the provisions of the Plan. In return for those rights, the provider must agree that it will not pursue collection of amounts denied under the Claim Review and Audit Program from you. You also have full rights for appeal of the Allowable Claim Limits determination. Please refer to your Summary Plan Description for the Plan's procedures for appeals.

Should you have any questions regarding this notice or the amount you owe to the medical provider, please feel free to contact your TPA at (484) 555-1212.

Very truly yours,

Claims Department

Sample Explanation of Benefits

EXPLANATION OF BENEFITS

THIS IS NOT A BILL

John Green
4251 Chestnut Street
Boston, MA 15647

Group # xxxxxxxxxx
Date
Employee John Green
Patient John Green
Participant ID xxxxx-xxx-xxxx
EOB # xxxxx

Provider	Date of Service	Charges Submitted	Ineligible	Code	Discount	Copay	Deductible	% Plan Pays	Benefit Payable
Chestnut Hospital	3/14/14 – 3/16/14	$4,876.00	$2,890.00	1		$300		70%	$1,390.20

The percentage(s) payable or any patient deductible(s) or co-pay(s) has been applied in accordance with the schedule of benefits in the Summary Plan Description.

EXPLANATION OF (CODE)

1: These charges exceed the Plan's Allowable Claim Limit; therefore, the charges have been denied as stated in the exclusions and limitations in your Summary Plan Description. Appeal rights under this Plan also apply to providers of Service.

SEE BACK FOR APPEAL PROCESS

SUMMARY OF SUBMITTED CHARGES

Total Submitted Charges	$4,876.00	Ineligible Charges	$2,890.00
Total Benefits Paid (by plan)	$1,390.20	Deductible	
Total Discount		Co-Pay	$300.00
		Patient's Co-Insurance	$295.80
Other Insurance Carrier Payment		Total Due to Provider (by member)	$595.80

Sample Notice of Adverse Benefits

12/12/2014

To: Manager, Patient Accounts

01 Sample Street

Chester Springs, PA 19425

Re: Sample Group (the "Plan")

Sample Hospital - Account #

Date(s) of Service Beginning: 10/27/2014

DEAR PATIENT ACCOUNTS MANAGER:

This notice is being provided to you as Notice of Adverse Benefit Determination for the above-referenced claim(s), and your rights under the Plan.

The Plan covering the patient is a self-funded welfare benefit plan as defined under the Employee Retirement Income Security Act of 1974, as amended (ERISA), and complies with all federal laws that govern such plans. You submitted a claim for payment amount of $2,108.10. For the reasons set forth below, the Plan Administrator has determined that certain charges in the amount of $737.84 must be denied in accordance with the terms of the Claim Review and Audit Program provisions of the Plan.

SPECIFIC PLAN PROVISIONS

The Plan provision that is the basis for this claim determination may be found in the Summary Plan Description under the heading, "Claim Review and Audit Program". This provision limits covered expenses under the Plan to those within the "Allowable Claim Limits". "Allowable Claim Limits" means the charges for services and supplies included as covered medical expenses under the Plan which are medically necessary for the care and treatment of illness or injury, but only to the extent that such fees are within the limits and allowances identified in the Summary Plan Description Schedule of Benefits for certain treatment types, services and supplies.

SPECIFIC REASONS FOR DENIAL

A comprehensive bill review has been performed on this claim(s). The enclosed audit report lists, in detail, the charges that are being denied due to apparent billing errors or charges which exceed this Plan's Allowable Claim Limits. The Allowable Claim Limits represent the Plan's internal rules, guidelines and protocols relied upon in the determination.

YOUR APPEAL RIGHTS

ERISA provides for a Plan participant to appeal a denial of benefits under the Plan, and the participant has been so informed. **In an effort to protect the Plan participant and fairly resolve any dispute of a benefit denial, this Plan also allows for a provider of service, as an Authorized Representative, to have full appeal rights in addition to those rights afforded by law to a participant.** When you, as the provider of service, exercise your right of appeal under the terms of this Plan, you are agreeing to the terms and conditions through which this right is granted, including your agreement to pursue recovery of certain denied expenses directly from the Plan and waiving any right to recover those certain expenses from the Plan participant. In return for this agreement, you will be accorded the same rights that are accorded under the Plan to a Plan participant. The Plan provision allowing for your appeal, in pertinent part, is explained below.

PROVIDER OF SERVICE APPEAL RIGHTS

A claimant may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied claim. An assignment of benefits by a claimant to aprovider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to ensure a full and fair review of the denied claim, and as a courtesy to a provider of service that is not an Authorized Representative, the Plan will consider an appeal received from the provider in the same manner as a claimant's appeal, and will respond to the provider and the claimant with the results of the review accordingly. Any such appeal from a provider of service must be made within the time limits and under the conditions for filing an appeal in accordance with the Plan provisions. **Providers requesting such appeal rights under the Plan must agree to pursue reimbursement for covered medical expenses directly from the Plan, waiving any right to recover such expenses from the claimant, and comply with the conditions of the sections related to appeals.**

For purposes of this section, the provider's waiver to pursue covered medical expenses **does not include** the following amounts, which will be the responsibility of the claimant:

- Deductibles
- Copayments
- Coinsurance
- Penalties for failure to comply with the terms of the Plan
- Charges for services and supplies which are not included for coverage under the Plan, and
- Amounts which are in excess of any stated Plan maximums or limits*

***Note: this does not apply to amounts found to be in excess of Allowable Claim Limits, as defined in the Summary Plan Description section, "Claim Review and Audit Program".** *The provider is agreeing to waive the right to balance bill for these amounts.*

Also, for purposes of this provision, if a provider indicates on a Form UB or on a Form HCFA (or similar claim form) that the provider has an assignment of benefits, then the Plan will require no further evidence that benefits are legally assigned to that provider.

Contact the Claims Administrator or the Plan Administrator for additional information regarding provider of service appeals.

REQUIREMENTS FOR INTERNAL APPEAL

1. You may appeal this benefit denial to the named fiduciary of the Plan by filing a request for review under the Plan's procedures and as described below.
2. You must file your request for review within 180 days of the date you receive this Notice of Adverse Benefit Determination by submitting a written request for review by hand, or by first-class mail, to:

   Appeals, Claims Department

   Sample TPA

   01 Sample Street

   City Name, State Zip Code

   Please note: Letters received by the Plan must explicitly state that an appeal is being requested, and must be accompanied by the information and documentation necessary for a full and fair review.
3. You must include a statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim.
4. You must include any material or information that you have which indicates that the expenses are covered under the Plan.
5. In connection with your appeal, you **must** submit written comments, documents, records and other information relating to any denied or partially denied charge included in this benefit denial. Failure to include any theories or facts in the appeal will result in those theories being deemed waived. In other words, you will lose the right to later raise factual arguments and theories which support this claim if you fail to include them in the appeal.

ADDITIONAL INFORMATION NECESSARY TO PERFECT YOUR CLAIM

For any charges excluded in the calculation of Allowable Claim Limits, you will find an Adjustment Code explanation in the audit review report. Following is an explanation of what is required in order for you to perfect the claim for benefits for each Adjustment Code:

1. Adjustment Code 'C': **Cost-to-charge ratio.** Allowable Claim Limits have been determined by using the most recent departmental cost/charge ratios as reported to CMS by the provider plus an additional 12%. Please submit documentation for any adjustment to the cost/charge ratio or actual cost to the provider for the service or supply.
2. Adjustment Code 'R': **Reduced to 112% of Redbook's Average Wholesale Price (AWP)**. Please submit documentation in support of a higher AWP.
3. Adjustment Code 'I': **Medical and Surgical Supplies, Implants, Devices.** Please submit invoices, receipts, cost lists or other appropriate documentation to evidence the cost to the provider.
4. Adjustment Code 'P': **90th Percentile of the Physician's Fee Reference (PFR)**. Please submit documentation establishing that the fee for the services does not exceed the 90th percentile for the services under the Physician's Fee Reference.

5. Adjustment Code 'M': **Medicare allowed amount.** Allowable Claim Limits have been determined by using the Medicare allowable amount for the claim plus an additional 20%. Please submit documentation that the charges do not exceed the allowed amount under Medicare plus 20%.
6. Adjustment Code 'A': **Ancillary.** Please submit documentation showing any variance which the Plan should consider as "industry standard".
7. Adjustment Code 'U': **Unbundled.** Please submit documentation showing that the charges should not be included in a global procedure code and/or are not included in departmental charges.
8. Adjustment Code 'E': **Error in billing.** Please submit documentation showing that these charges were not billed in error.
9. Adjustment Code 'Q': **Quantity change.** Please submit documentation to support the quantity of items or services billed which are not supported in the medical records.
10. Adjustment Code 'N': **Not able to identify or understand.** Please submit information which will clearly identify the service or supply.

REVIEW IN THE EVENT OF ADVERSE BENEFIT DETERMINATION

When you file an appeal, as described above, the Plan Administrator will provide a full and fair review of this benefit denial according to the Plan's procedures.

In the case of an adverse benefit determination on review, the Plan Administrator shall provide, on request and free of charge, access to, and or copies of, documents, records, and other relevant information used in making the initial determination of Allowable Claim Limit.

The review will take into account all comments, documents, records and other information submitted that directly and specifically relates to the denied or partially denied charges set forth in the spreadsheet review. This would include any applicable physician and nurse notes, logs, chart details, invoices, receipts, cost lists, statements, explanations and any similar information related specifically and directly to each charge denied or partially denied and not submitted previously. The review on appeal will be a "fresh" look at your claim without deference to this initial benefit denial. It will be conducted by a person who was not involved in this initial benefit denial, and who is not a subordinate of the individual involved in this initial benefit denial.

TIME PERIOD FOR DECISION ON A REQUEST FOR REVIEW

The Plan will notify you of the decision on your request for review within a reasonable time but not later than 30 days after the Plan receives your request for review.

DECISION ON APPEAL TO BE FINAL

Please note that this Plan contains provisions for an External Review following a final internal adverse benefit determination. External reviews are not, however, available for a denial, reduction, termination or refusal to provide payment for a benefit which is based on a determination that an individual is not eligible under the Plan, or the claim denial did not have a medical component. A medical component includes denials based upon the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of the health care service or treatment requested, or a determination that a treatment is experimental or investigational, or a rescission of coverage.

External review rights do not include denials that involve only contractual or legal interpretation without any use of medical judgment. In these cases, no external review is available.

Failure by the Plan to follow the appeals procedures set forth in the Summary Plan Description may allow a claimant the right to an external review of an eligible claim denial without satisfaction of any further internal appeal requirements. Please refer to the Summary Plan Description for detailed information.

If, for any reason, you do not receive a written response to the appeal within the appropriate time period set forth above, you may assume that the appeal has been denied. The Plan Administrator's decision on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.**

When the Plan's appeal procedures have been exhausted, you will have the right to bring a civil action under ERISA § 502(a) if your request for coverage or benefits is denied following review.

Please contact the undersigned if you have any questions or require any additional information regarding the Plan provisions applicable to this claim(s) and/or the conditions under which these appeal rights are being granted.

Sincerely,

Claims Department

Sample Medicare Audit

TPA	
Group	Sample Group
Claim #	
Provider	Sample Provider
Patient	Sample Patient
Pt Act #	
DOS	
NPI	
TPA X-Ref	

Audit Completion Date	**11/14/2014**
Total Amount Billed	**$1,602.00**
Reduction	**$1,351.484**
Allowable Claim Limit	**$250.52**

REV Code	Item Description	CPT/ NDC	QTY	Total Charge	Cost Each	C-C/R Adjusted Allowance	Medicare OPPS Adjusted Allowance	Adj. Code(s)	Cost Ratio
0320	X-ray exam of foot	73630	1	$475.00	$475.00	$0.00	$64.20	M	0.473820
0450	Emergency dept visit	99283	1	$1,127.00	$1,127.00	$0.00	$186.32	M	0.473820
	TOTAL			**$1,602.00**		**$0.00**	**$250.52**		

CODES	REDUCTION
M Allowable claim limit is Medicare allowed amount, in geographic region, plus 20%.	**$1,351.48**
** Cost to Charge is not applicable for this service.	**Total: $1,351.48**

MAIN DIAGNOSIS CODES

924.3 Contusion of toe
E91.74
E84.95

ADMITTING DIAGNOSIS CODE

MAIN PROCEDURE (OR CPT) CODES

Sample Cost to Charge Audit

TPA	
Group	Sample Group
Claim #	
Provider	Sample Provider
Patient	Sample Patient
Pt Act #	
DOS	
NPI	
TPA X-Ref	

Audit Completion Date	**11/19/2014**
Total Amount Billed	**$15,020.00**
Reduction	**$10,976.54**
Allowable Claim Limit	**$4,043.46**

	ADJUSTED DRG ALLOWANCE	C-C/R ADJUSTED ALLOWANCE	ADJ. CODE
Allowable Claim Limit	$3,839.84	$4,043.46	Adjustment code C was the basis of claim determination. See adjustment codes at line level for additional information.

MEDICARE ALLOWANCE

DRG: 775 DRG Desc: VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES

Adjustment Code M Calculation **Medicare +20%**

REV Code	Item Description	CPT/ NDC	QTY	Total Charge	Cost Each	C-C/R Adjusted Allowance	Adj. Code(s)	Cost Ratio
0110	R&B - Private - General		1	$1,845.00	$1,845.00	$979.10	C	0.473820
0110	R&B - Private - General		1	$1,846.00	$1,846.00	$979.63	C	0.473820
0250	Pharmacy - General		1	$48.00	$48.00	$3.38	C	0.062945
0259	Pharmacy - Other		16	$335.00	$20.94	$23.62	C	0.062945
0272	Med/Surgical Supplies & Devices - Sterile Supply		1	$48.00	$48.00	$6.55	C	0.121917
0300	Laboratory - General		2	$226.00	$113.00	$8.56	C	0.033833
0301	Laboratory - Chemistry		1	$564.00	$564.00	$21.37	C	0.033833
0302	Laboratory - Immunology		4	$808.00	$202.00	$30.62	C	0.033833
0305	Laboratory - Hematology		2	$870.00	$435.00	$32.97	C	0.033833
0306	Laboratory - Bacteriology & Microbiology		1	$181.00	$181.00	$6.86	C	0.033833
0636	Pharmacy - Ext of 025X - Drugs Requiring Detailed Coding		3	$178.00	$59.33	$12.55	C	0.062945
0722	Labor Room/Delivery - Delivery		1	$8,071.00	$8,071.00	$1,938.25	C	0.214420
	TOTAL			**$15,020.00**		**$4,043.46**		

CODES	**REDUCTION**
C Reduced to allowable claim limit of 112% of department-specific cost-ratio, as reported to CMS	**$10,976.54**
	Total: $10,976.54

MAIN DIAGNOSIS CODES

664.01	Del w 1 deg lacerat-del
655.81	Fetal abnorm NEC-deliver
V27.0	Deliver-single liveborn
V04.81	Vaccin for influenza
V06.4	Vac-measle-mumps-rubella
V06.1	Vaccination for DTP-DTaP

ADMITTING DIAGNOSIS CODE

664.01	Del w 1 deg lacerat-del

MAIN PROCEDURE (OR CPT) CODES

75.69	Repair ob laceration NEC
72.79	Vacuum extract del NEC

An appeal occurs when the provider disagrees with a benefit determination made by their Plan.

When a benefit determination is made by the Plan, the Plan issues a Notice of Adverse Benefit Determination (NoABD) letter to the provider of service. This letter explains how the claim was processed and if any portion of the claim was denied, the reason for denial.

The NoABD advises the provider how to file an appeal with the Plan if they disagree with the Plan's determination on the claim. From the date the provider receives the NoABD letter, they have 180 days to file a first level appeal to the Plan (or directly to ELAP services). By filing an appeal the provider rescinds their right to balance bill the patient.

If a claim audited by ELAP is appealed, ELAP will respond to this first level appeal. If the appeal results in an additional allowance, additional money is sent to the provider by the Plan. However, if the appeal is denied, the provider has the right to file a second level appeal. This second level appeal must be filed by the provider within 60 days of the date they received the determination from the first level appeal. ELAP will respond to this second level appeal. If it is determined that additional funds are due, additional money is sent to the provider by the Plan.

All claim review procedures provided for in the Plan must be exhausted before any legal action can be brought by the provider against the Plan. Any legal action for the recovery of any benefits must be commenced within three years after the Plan's claim review procedures have been exhausted.

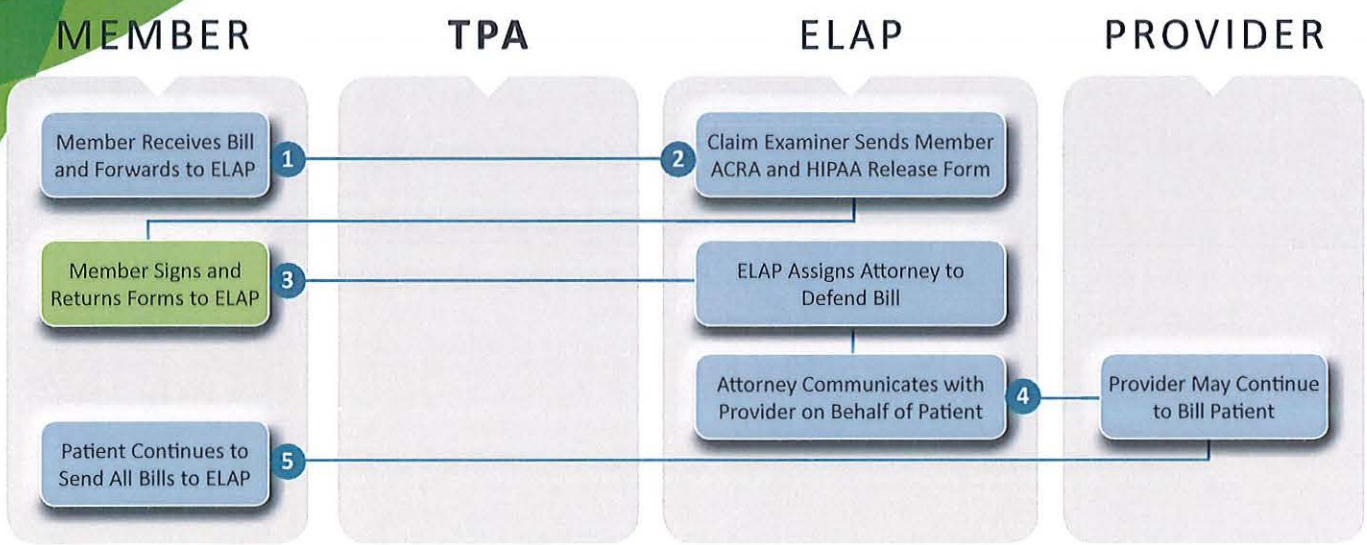
FOR ERISA GROUPS ONLY

You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

You have the right to bring an action under section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), 29 U.S.C. §1132(a), following an adverse benefit determination of final review.

The Balance Bill Process

If you receive a balance bill for services provided to you from a facility that represents ineligible charges and not your co-pay, deductible, or co-insurance amount, please follow the steps as outlined below:



1. If you receive a balance bill for an amount that **exceeds your patient responsibility**, forward it on to ELAP via:

Phone: (800) 977-7381 Monday – Friday
A live representative is available 9am – 7pm EST
If a representative is not available, leave a message for next day call back

Email: balancebills@elapservices.com

Fax: (888) 560-2447
An ELAP fax sheet is available on the next page

Mail: 1550 Liberty Ridge, Suite 330
Wayne, PA 19087

2. ELAP will confirm that they have received your balance bill, and will send you the Attorney Client Representation Agreement (ACRA) and HIPAA Release forms to sign. At this time ELAP will also assign a Claims Examiner to work on your case.
3. Sign all forms and return them to ELAP as soon as possible. ELAP's attorneys cannot begin to defend your case without the signed ACRA and HIPAA Release forms.
4. Once ELAP has received all signed release forms, an attorney will be assigned to your case. The attorney will communicate with the facility on your behalf and work towards resolving the balance bill.
5. The provider may continue to balance bill you. This is within the provider's legal rights. Continue to contact ELAP each time you receive a bill, phone call, or other provider contact. **Please note that it is important that your out-of-pocket requirements are paid as soon as possible.** An outstanding patient portion can slow the defense process.

Balance Bill Fax/Email Cover Page

Email: balancebills@elapservices.com **Fax Number:** (888) 560-2447

DATE	TOTAL NO. OF PAGES (Including Cover)
FROM	PHONE:

REMINDER – ONLY FAX BILLS THAT HAVE BEEN AUDITED BY ELAP SERVICES. CONTACT YOUR BENEFITS DEPARTMENT WITH ANY QUESTIONS.

MEMBER NAME	
PATIENT NAME	
COMPANY/GROUP#	
MEMBER/PATIENT CONTACT INFORMATION	PHONE - WORK
	PHONE - CELL
	FAX NUMBER
	EMAIL
PREFERRED METHOD OF CONTACT	
FACILITY	
DATE OF SERVICE	
COMMENTS	

IMPORTANT

This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.

Attorney Client Representation Agreement And HIPAA Release Form

When members send in their first balance bill, they will receive two forms from the Claims Examiner that must be signed and returned to ELAP before any defense of a balance bill can begin. The first of these two forms is the Attorney Client Representation Agreement (ACRA). By signing the ACRA, members give their assigned attorney permission to respond to any balance bills on their behalf and defend the Plans payment as full and final. The second document is the HIPAA Release Form, which gives the attorney permission to view the member's private health information relative to the claim being balance billed.

It is crucial that members sign and return both of these documents as soon as possible. Their attorney cannot begin the defense process without a signed and returned ACRA and HIPAA Release Form. Unreturned forms will result in a delay of the defense process.

SAMPLE ATTORNEY-CLIENT REPRESENTATION AGREEMENT

This Attorney-Client Representation Agreement (the "Agreement") confirms the terms and conditions upon which Sample Attorney (the "Firm") will provide legal services to Sample Client (the "Client") as a client of the Firm. The parties to this Agreement are the Firm and the Client. This Agreement sets forth the scope of the Firm's engagement as legal counsel to the Client and confirms that we are in mutual agreement with respect to the same. This Agreement will not take effect, and the Firm will have no obligation to provide legal services to Client, until Client returns a signed copy of this Agreement. Client understands and acknowledges that Client has the choice not to hire the Firm to represent Client in this matter, and in such event, the Firm will not represent the Client.

The Client retains and employs the Firm to represent the Client's interests with respect to certain medical bills from Sample Provider ("Medical Provider"), which is a hospital and/or medical facility whose medical bills were audited by ELAP Services, LLC ("ELAP") on behalf of Client's healthcare plan. This representation does not include representing the Client for physician bills or other medical bills that were not audited by ELAP, and the Firm specifically does not represent Client for any such medical bills that were not audited by ELAP. ELAP is a co-fiduciary of Client's healthcare Plan.

The Firm's legal fees and expenses for the representation of Client are paid by ELAP. The Client will never owe the Firm any money for legal fees or expenses. Client acknowledges that if not already paid, the Client may owe a co-pay and/or deductible amount to the Medical Provider as reflected on the Explanation of Benefits document(s) related to the medical bill(s) at issue.

The Firm employs several attorneys, who collectively hold active licenses to practice law in a majority of the states. Due to certain state bar rules or any other reason as determined by the Firm, it may become necessary for the Firm to associate attorneys and/or law firms that are not employed by the Firm. The Firm is hereby authorized to associate outside attorneys and/or law firm(s) to assist the Firm in representing the Client. Any such other outside attorneys and/or law firm(s) that are associated by the Firm to assist in the representation of the Client shall also be bound by this Agreement. Client will never owe any money for legal fees or expenses to any attorney or law firm associated by the Firm to assist in the representation of Client.

As it relates to medical care that is the subject of this Agreement, reimbursement to the Medical Provider has been calculated based on the Allowable Claim Limit as defined in the Client's applicable health benefit plan. The Medical Provider may claim that the Client, ELAP, the Client's health benefit plan, and/or the third party administrator owe additional payment to the Medical Provider. It is the position of the Firm that the Medical Provider has been paid fair and reasonable reimbursement for the medical care and services rendered to Client upon the Medical Provider's receipt of the monies owed to it as described in the Explanation of Benefits for the medical care at issue. Although Client has the option to appeal the payment determination made by Client's health benefits plan, the Firm does not intend to pursue such appeal on behalf of Client, and Client hereby acknowledges and agrees with that course of action by the Firm. If Client wishes to pursue such an appeal to the Client's health benefit plan, Client may opt to do that without the assistance of the Firm. Client's health benefits Plan provides a procedure for appeal directly by the Medical Provider at issue. The Firm will encourage the Medical Provider to appeal to the health benefit Plan for additional payment.

Client hereby understands and acknowledges that the Firm currently represents ELAP and expects to continue to represent ELAP on an on-going basis. Client hereby understands and acknowledges that the Firm may also represent the Client's health benefit Plan and/or the third party administrator that administers the Client's health benefit plan. In addition to representing the Client, the Firm may also jointly represent ELAP, the Client's health benefit plan, and/or the third party administrator. Such joint representation may include claims made against any number of those entities by the Medical Provider regarding reimbursement for the medical treatment at issue in the Firm's representation of Client. The Medical Provider may seek to claim or otherwise suggest that a conflict of interest exists by the Firm's joint representation of these various parties regarding this matter. To the extent that any perceived conflict may exist relating to the Firm's joint representation of multiple parties in this matter, Client hereby waives any such conflict. Client hereby understands that this waiver is voluntary, and may be revoked at any time in writing signed by the Client and delivered to the Firm.

The Client shall have the right to terminate and discharge the Firm at any time. The termination or discharge of the Firm must be in writing. In such event, the Client authorizes the Firm to make and retain a duplicate copy of the Client's file. In addition, the Client agrees that the Firm may withdraw from representing the Client upon written notice sufficient to enable the Client to retain new counsel. Without limitation, the Firm can withdraw as counsel: (1) if the Firm decides to cease the practice of law; (2) in the event that the Client does not provide reasonable cooperation in the matter; or (3) for any reason authorized by the applicable rules of Professional Conduct.

This Agreement correctly sets forth the Firm's and Client's understanding of the scope of the services to be rendered to Client by Firm. No variance, change,modification or augmentation of this Agreement shall be effective unless and until confirmed in writing, signed by the Firm and the Client, and making express reference to this Agreement. This document embodies the whole agreement of the parties. There are no promises, terms, conditions or obligations other than those contained herein, and this contract shall supersede all previous communications, representations, or other agreements, either verbal or written, between the Firm and the Client. Client understands and acknowledges that at any time, Client is permitted to seek the advice of other counsel of Client's choice in respect to this Agreement and/or the Firm's representation of Client in this matter.

This Agreement is hereby agreed to and entered by Client.

.....

Sample Client

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Client's Best Telephone Number(s) for Firm Contact

Sample HIPAA Release Form

TO WHOM IT MAY CONCERN,

Re: Sample Plan (the Plan)

Patient: Sample Patient

For: All Medical Bills for the facility/hospital listed above

I am represented in this matter by the law firm of Sample Firm. Please direct all future correspondence to them at:

Sample Firm, 1180 Rosewood Drive St., Suite 2900, Boston, MA 1234

Phone: (555) 048-7221

Furthermore and as regards the potential necessity for my attorney to see my "Protected Health Information" *(or "PHI", as defined in 45 CFR § 160.103, which is part of the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164, subparts A and E, (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"))*; I do authorize Sample Provider to release this PHI to, and discuss it with, my attorney at Sample Firm.

However, this letter hereby revokes any waiver of my HIPAA privacy rights as obtained by Sample Provider and also revokes any previous HIPAA authorizations that would enable Sample Provider to disseminate any of my confidential medical records and/or PHI, to any third party other than my attorney, my employee health plan, or third party administrator of my employee health plan.

Thank you and sincerely,

.....

Sample Member

.....

Date of Birth

.....

Social Security Number

.....

cc: Sample Firm

Client Reporting

Your Client Relationship Manager will send you monthly reporting.
This report contains the following information:

- **Summary of your Plan's monthly, annual and overall program performance including: number of claims audited, billed charges, audit allowance, ELAP fee, total cost to Plan, and savings.**
- **Appeals Summary showing the total number of appeals and additional allowances paid, if any.**
- **Balance Bill Summary showing the number of bills received, opened, closed and reopened during the month along with their dollar amount. Additionally, the summary reflects any claims that may be in collections, litigation or have had a credit impairment.**

Your Client Relationship Manager is available to discuss any questions or concerns you have regarding this monthly and will reach out to you monthly or at your direction to review your Plan's performance and operations.

A sample end of the month report follows.

Sample EOM Report

RESULTS REPORT FOR JUNE 2014
SAMPLE CLIENT GROUP

**Values represent sample information*

Audit Program

	# Audits	Total Billed	Audit Allowance	ELAP Fee	Total Plan Costs	Savings, $	Savings, %
June 2014	16	$22,243.43	$4,989.17	$2,665.50	$7,654.67	$14,588.76	65.59%
2014 (May YTD)	118	$894,369.71	$181,660.80	$99,992.80	$281,653.60	$612,716.11	68.51%
2013	259	$1,756,660.49	$414,334.34	$204,696.13	$619,030.47	$1,137,630.02	64.76%
2012	242	$1,619,802.89	$412,301.31	$191,842.33	$604,143.64	$1,015,659.25	62.71%
Total	**635**	**$4,293,076.52**	**$1,013,285.62**	**$499,196.76**	**$1,512,482.38**	**$2,780,594.14**	**64.77%**

Direct Contracts

	# Audits	Total Billed	Audit Allowance	ELAP Fee	Total Plan Costs	Savings, $	Savings, %
2013	19	$165,653.80	$80,191.89	$12,110.10	$92,301.99	$73,351.81	44.28%
2012	13	$105,169.63	$25,776.68	$4,419.57	$30,196.25	$74,973.38	71.29%
Total	**32**	**$270,823.43**	**$105,968.57**	**$16,529.67**	**$122,498.24**	**$148,325.19**	**54.77%**

Single Patient Contracts

	# Audits	Total Billed	Audit Allowance	ELAP Fee	Total Plan Costs	Savings, $	Savings, %
June 2014	1	$3,696.75	$2,587.73	$221.81	$2,809.54	$887.21	24.00%
2014 (May YTD)	3	$24,585.27	$14,373.75	$1,475.12	$15,848.87	$8,736.40	35.54%
2013	7	$150,733.67	$107,152.69	$13,336.23	$120,488.92	$30,244.75	20.07%
2012	7	$103,848.29	$67,058.35	$5,672.52	$72,730.87	$31,117.42	29.96%
Total	**18**	**$282,863.98**	**$191,172.52**	**$20,705.68**	**$211,878.20**	**$70,985.78**	**25.10%**

Sample EOM Report

APPEALS SUMMARY	1ST APPEAL	2ND APPEAL
Total Appeals Received	12	0
Appeals Received in June 2014	3	0
Closed Appeals	7	0
Total Additional Allowance Paid	$443.33	$0.00

BALANCE BILL SUMMARY	TOTAL # OF BB	TOTAL $ OF BB
Open Balance Bills as of 5/31/2014	46	$537,576.67
Balance Bills Received in June 2014	9	$210,131.42
Balance Bills Reopened	1	$19,574.22
Balance Bills Closed in June 2014	5	$14,508.39
Closed Inactive in June 2014	3	$14,177.30
Closed Settled in June 2014	2	$331.09
Open Claims as of 6/30/2014	51	$752,773.92
Claims in Collection as of June 2014	19	$419,086.24
Credit Impairments as of June 2014	2	$42,437.51
Claims in Litigation as of June 2014	0	$0.00

Frequently Asked Questions

A PROVIDER IS STATING THAT THEY DO NOT ACCEPT MY INSURANCE, WHAT DO I DO?

It is likely that they do not recognize the Physicians Only logo on the ID card. Explain that you have health benefits and request that they call your TPA to verify your benefits—the number is on your ID card. If you are still having difficulties call your TPA for assistance.

COULD THE PROVIDER ASK ME TO PAY FOR MY PROCEDURE UPFRONT?

The hospital performing your medical procedure may request money from you upfront however you as the Patient are only responsible for your co-pay, co-insurance and deductible. To confirm this dollar amount, contact your TPA. You can also refer to your Employee Benefit Booklet in the SCHEDULE OF BENEFITS. The only out-of-pocket that you should pay upfront is your co-pay. Your deductible and co-insurance is determined once the hospital has sent their bill to your TPA. This amount will be listed on your Explanation of Benefits.

WHAT IF THE PROVIDER ASKS ME TO PAY MORE THAN MY OOP?

Your benefits Plan does not require you to pay anything upfront outside of your co-pay, co-insurance or deductible. If the provider will not perform your treatment without money being paid upfront outside of your personal responsibility, contact your TPA immediately and have a your TPA Representative speak to the provider.

I'VE BEEN BALANCE BILLED; WILL MY ACCOUNT BE PUT INTO COLLECTIONS?

Each provider treats their billing practices differently. When a provider sends a bill to a collection agency, it does not necessarily mean that it was reported to any credit reporting agency impacting your credit score. This means that the provider has ceased their collection efforts within the hospital billing department and sent your bill to an outside vendor to attempt to collect the alleged balance due. If you receive a collection notice, please send it to ELAP right away. The collection notice will clearly state that you have 30 days to respond and dispute the debt and it must be sent to ELAP in a timely manner so that the attorney has enough time to respond on your behalf. It is very important to remember that if your bill is sent to collections, once the collection agency is made aware that you are represented by an attorney they are no longer, by law, permitted to communicate with you in any way other than continued mail notices. Please contact ELAP immediately if you continue to be contacted by the collection agency.

WHY IS THE PROVIDER CENTER STILL CALLING ME?

The provider is within their legal rights to attempt to contact you by telephone, but there is no reason for you to speak to them. If you do speak to a representative, take their name and their phone number and relay that information to your assigned ELAP Claims Examiner.

HOW LONG WILL THE PROVIDER CONTINUE TO BILL ME?

Providers have different collection practices. Please be assured that ELAP will continue to support you throughout this process. It is important that you send ELAP all correspondence that you receive in a timely manner.

AM I EVER GOING TO BE RESPONSIBLE TO PAY THE BALANCE?

No. You've paid your responsibility in the form of co-pay, deductible, and co-insurance. Your attorney will continue to defend this bill through resolution.

WHAT IF I NEED ADDITIONAL TREATMENT AT THIS HOSPITAL/SURGERY CENTER? WILL THEY TURN ME AWAY?

It has not been ELAP's experience to have a provider turn away a member due to balance billing. If you encounter any admissions issues, please call your TPA right away so that ELAP and your TPA can work together to resolve the issue.

elap services

1550 LIBERTY RIDGE, SUITE 330 WAYNE, PA 19087